

Department of Human Services
Bureau of Human Service Licensing
LICENSING INSPECTION SUMMARY PUBLIC

June 26, 2025

[REDACTED]
TWINING RETIREMENT COMMUNITY LLC
[REDACTED]

RE: HOLLAND SENIOR LIVING
COMMUNITY
1400 OLD JORDAN ROAD
HOLLAND, PA, 18966
LICENSE/COC#: 14657

[REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 04/14/2025 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Please note that you are required to post this Licensing Inspection Summary at your facility in a conspicuous location.

Sincerely,
[REDACTED]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: HOLLAND SENIOR LIVING COMMUNITY **License #:** 14657 **License Expiration:** 08/30/2025
Address: 1400 OLD JORDAN ROAD, HOLLAND, PA 18966
County: BUCKS **Region:** SOUTHEAST

Administrator

Name: [REDACTED] **Phone:** [REDACTED] **Email:** [REDACTED]

Legal Entity

Name: TWINING RETIREMENT COMMUNITY LLC
Address: [REDACTED]
Phone: [REDACTED] **Email:** [REDACTED]

Certificate(s) of Occupancy

Type: Other **Date:** 03/13/1989 **Issued By:** CWOPA L&I

Staffing Hours

Resident Support Staff: **Total Daily Staff:** 80 **Waking Staff:** 60

Inspection Information

Type: Partial **Notice:** Unannounced **BHA Docket #:**
Reason: Monitoring **Exit Conference Date:** 04/14/2025

Inspection Dates and Department Representative

04/14/2025 - On-Site [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 152 **Residents Served:** 51

Secured Dementia Care Unit

In Home: Yes **Area:** Fairview Court **Capacity:** 25 **Residents Served:** 9

Hospice

Current Residents: 6

Number of Residents Who:

Receive Supplemental Security Income: 9 **Are 60 Years of Age or Older:** 51
Diagnosed with Mental Illness: 0 **Diagnosed with Intellectual Disability:** 0
Have Mobility Need: 29 **Have Physical Disability:** 1

Inspections / Reviews

04/14/2025 Partial

Lead Inspector: [REDACTED] **Follow-Up Type:** POC Submission **Follow-Up Date:** 05/04/2025

05/12/2025 - POC Submission

Submitted By: [REDACTED] **Date Submitted:** 05/30/2025
Reviewer: [REDACTED] **Follow-Up Type:** POC Submission **Follow-Up Date:** 05/17/2025

Inspections / Reviews *(continued)*

05/20/2025 POC Submission

Submitted By: [REDACTED]

Date Submitted: 05/30/2025

Reviewer: [REDACTED]

Follow Up Type: Document Submission Follow Up Date: 05/30/2025

06/26/2025 Document Submission

Submitted By: [REDACTED]

Date Submitted: 05/30/2025

Reviewer: [REDACTED]

Follow Up Type: Not Required

51 - Criminal Background Check

1. Requirements

2600.

51. Criminal History Checks - Criminal history checks and hiring policies shall be in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.101—10225.5102) and 6 Pa. Code Chapter 15 (relating to protective services for older adults).

Description of Violation

Staff person A was hired on [redacted], a criminal background check was not completed until [redacted]

Staff person B was hired on [redacted] a criminal background check was not completed until [redacted]

Repeat violation: [redacted] et al

Plan of Correction

Accept [redacted] - 05/12/2025)

Issue: 2 staff members had background checks completed after hire date.

Action: Administrator initiated inservice with Human Resource director on the due date of all criminal background checks. See attached.

Plan: Human Resource Director to pull all personal care staff members files to ensure background checks were completed by hire date by 5/15/25. Administrator pulled all direct care staff members to ensure background checks were completed by hire date by 4/20/25.

Sustain: To ensure that Holland Village stays in compliance, Administrator shall receive the criminal background check during orientation from human resources. Only after receiving the check, will the schedule for signed off with the staff member.

Licensee's Proposed Overall Completion Date: 05/15/2025

Implemented [redacted] - 06/26/2025)

63a - First Aid/CPR Training

2. Requirements

2600.

63.a. At least one staff person for every 50 residents who is trained in first aid and certified in obstructed airway techniques and CPR shall be present in the home at all times.

Description of Violation

On [redacted], from 3:00 PM to 11:00 PM, and 11:00 PM to 7:00 AM, [redacted] residents were present in the home. During this time only 1 staff person was present in the home who was certified in first aid, obstructed airway techniques and CPR.

On [redacted], from 3:00 PM to 11:00 PM, and 11:00 PM to 7:00 AM, [redacted] residents were present in the home. During this time only 1 staff person was present in the home who was certified in first aid, obstructed airway techniques and CPR.

On [redacted], from 3:00 PM to 11:00 PM, and 11:00 PM to 7:00 AM, [redacted] residents were present in the home. During this time only 1 staff person was present in the home who was certified in first aid, obstructed airway techniques and CPR.

Plan of Correction

Accept [redacted] - 05/12/2025)

Issue: 50:1 ratio of residents to staff was not met for CPR / First aide certification. Home had 51 residents on [redacted] and [redacted].

Action: Administrator initiated the inservice and education for Clinical Service Manager and scheduler on the proper ratio of staff to residents who are CPR / first aide certified. See attached. Administrator and scheduler readjusted

63a First Aid/CPR Training (continued)

the schedule for the remaining week to ensure compliance of violation 63a.

Plan: The Scheduler will always have at least 2 CPR and First Aide certified staff members to cover up to 100 residents in the home. A review of the schedule will be completed weekly between the scheduler and the administrator or designee. Administrator has completed the audit of staff members certification and has given the list to scheduler. Administrator and Human Resource director have implemented (as prior violation) the hiring will include already certified candidates or plan to acquire certification within 30 days of the hire date for all direct care staff members.

Licensee's Proposed Overall Completion Date: 05/06/2025

Implemented [redacted] 06/26/2025)

65i - Training Record

3. Requirements

2600.

65.i. A record of training including the staff person trained, date, source, content, length of each course and copies of any certificates received, shall be kept.

Description of Violation

The home's record of direct care staff training that occurred on [redacted] and [redacted], does not include the length of training and names all of the staff persons trained.

The home's record of direct care staff training that occurred on [redacted] and [redacted], does not include the length and source of training.

Plan of Correction

Accept ([redacted] - 05/12/2025)

Issue: Training did not include the length of the Abuse and Reporting that was held with the Ombudsman at 1.5 hours.

Action: New Inservice sheets were created by administrator to include the entire record of training. See attached for new sheet. Inservice to use and document on this sheet was implemented by administrator.

Plan: New Inservice / Training forms will be used going forward. The sheets were implemented as of this violation and are being used as seen on this entire report.

Licensee's Proposed Overall Completion Date: 05/06/2025

Implemented [redacted] 06/26/2025)

82c - Locking Poisonous Materials

4. Requirements

2600.

82.c. Poisonous materials shall be kept locked and inaccessible to residents unless all of the residents living in the home are able to safely use or avoid poisonous materials.

Description of Violation

An aerosol can of aquanet hair spray, with a manufacture's label indicating "keep out of reach of children, inhaling can be harmful or fatal", was unlocked, unattended, and accessible to residents in the secure dementia care unit activities room in a lower cabinet

82c - Locking Poisonous Materials (continued)

. Not all the residents of the home, including residents of the secure dementia care unit, have been assessed capable of recognizing and using poisons safely.

Repeat violation: [redacted] et al.

Plan of Correction

Accept [redacted] - 05/12/2025)

Issue: A can of hairspray was located in the unused lounge of SDCU which could be harmful to a resident.

Action: The can of hairspray was immediately removed by the Clinical Service Manager while surveyor was onsite.

The cabinet doors were immediately checked for any harmful materials and locked. Key shall remain with the Memory Care Coordinator. Inservice initiated by Clinical Service Manager and Administrator on the understanding of ANY area in memory care is at risk of harmful products.

Plan: Weekly rounds by nurses and management will resume to INCLUDE the lounge area. See attached for updated audit.

Licensee's Proposed Overall Completion Date: 05/09/2025

Implemented [redacted] - 06/26/2025)

91 - Telephone Numbers

5. Requirements

2600.

91. Emergency Telephone Numbers - Telephone numbers for the nearest hospital, police department, fire department, ambulance, poison control, local emergency management and personal care home complaint hotline shall be posted on or by each telephone with an outside line.

Description of Violation

There are no emergency telephone numbers to include the nearest hospital and fire department on or by the telephone in memory care on the nurse's desk.

Repeat violation [redacted] et al

Plan of Correction

Accept [redacted] - 05/20/2025)

Issue: The emergency numbers were not by the phone located at the nurses station. The emergency number and contacts were in the book located to the left of the phone in a cabinet as to keep them non accessible to residents should they wander behind the desk.

Action: The emergency number stickers were placed on each of the nurses station phones while onsite.

Plan: Inservice initiated by Administrator to Administrative Secretary and Clinical Service Manager for proper location of the information. See attached. Completed by 5/9/25.

Sustain: The monthly audit that is completed by the med techs and nurses has been updated to have the phone stickers for the nurses station added. It is already on the room audits. See attached.

ADD THE ROOM AUDITS.

Licensee's Proposed Overall Completion Date: 05/12/2025

Implemented [redacted] - 06/26/2025)

95 - Furniture and Equipment

6. Requirements

2600.

95. Furniture and Equipment Furniture and equipment must be in good repair, clean and free of hazards.

Description of Violation

There was a smoke detector near room [REDACTED] that was dangling from the ceiling by its wires.

Plan of Correction

Accept [REDACTED] - 05/20/2025)

Issue: Smoke head was observed hanging down from the ceiling by apartment [REDACTED]

Action: Maintenance will notified immediately of the issue and was corrected onsite.

Plan: All staff will be inserviced on proper notification of any furniture or equipment not in working order by administrator by 5/10/25. See attached with the initial training.

Sustain: Maintenance or Admin make plant rounds weekly and document any issues that need to be addressed. This review was implemented on 4/20/25. See attached.

Licensee's Proposed Overall Completion Date: 05/24/2025

Implemented ([REDACTED] - 06/26/2025)

121a Unobstructed Egress

7. Requirements

2600.

121.a. Stairways, hallways, doorways, passageways and egress routes from rooms and from the building must be unlocked and unobstructed.

Description of Violation

On [REDACTED] at 9:18 AM, the gate door and keypad in the memory care courtyard was inoperable. The keypad gave no feedback when pressed and door remained securely locked. Exits leading to the courtyard indicate this is an emergency fire exit. The home stated this exit has been inoperable for at least 2 weeks.

Plan of Correction

Accept [REDACTED] - 05/20/2025)

Issue: Courtyard gate keypad was found to be inoperable during inspection. The outside keypad is working. It should be noted that there is another exit available, but we take this violation knowing that if it is stated that this is an exit, it must be used as such. This is not an exit or entryway for staff and is not used.

Action: Director of Maintenance immediately contacted the contractor and was scheduled to access and repair.

Inservice initiated by Administrator to educate maintenance for checking all exterior exits in memory care. All alarms and exits are in working order. Repair was completed. Awaiting invoice to show proof. Maintenance staff was educated that in the event of an emergency, the other 4 exits should be used.

Sustain: Maintenance or Admin make plant rounds weekly and document any issues that need to be addressed. This review was implemented on 5/7/25. See attached.

Licensee's Proposed Overall Completion Date: 05/25/2025

Implemented ([REDACTED] - 06/26/2025)

183b Meds and Syringes Locked

8. Requirements

2600.

183.b. Prescription medications, OTC medications, CAM and syringes shall be kept in an area or container that is locked. This includes medications and syringes kept in the resident's room.

Description of Violation

On [REDACTED] at 9:19 AM, a medication cart was

183b - Meds and Syringes Locked (continued)

unlocked, unattended, and accessible in in the memory care dining room. Two residents were dining nearby.

At 1:37 PM, a medication cart was unlocked, unattended, and accessible in in the open nurses area in the lower west wing. there were no staff members nearby.

Plan of Correction

Accept (████) - 05/20/2025)

Issue: Two staff member left cart unlocked not pushing the door shut all of the way. The cart is in working order.

Action: The door was immediately closed when staff was notified. Inservice was initiated by the Clinical Service Manager on importance and guidelines of the regulations and why.

Plan: All nursing staff member will be educated by the clinical service manager by 5/14/25 to ensure that the med carts are locked while there is no staff member using them.

Sustain: Random walk throughs will be completed by Administrator and Clinical Service Manager 3 times weekly for 2 weeks, 2x weekly for 2 weeks and then weekly for a month. Walkthroughs started on 4/20/25 as stated on the audit sheet.

Licensee's Proposed Overall Completion Date: 05/13/2025

Implemented (████) - 06/26/2025)

231b - Medical Evaluation

9. Requirements

2600.

231.b. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner, documented on a form provided by the Department, within 60 days prior to admission. Documentation shall include the resident's diagnosis of Alzheimer's disease or other dementia and the need for the resident to be served in a secured dementia care unit.

Description of Violation

Resident █████ was admitted to the █████ on █████; however, the resident's medical evaluation was completed on █████.

Plan of Correction

Accept (████) - 05/20/2025)

Issue: Resident admitted to Memory Care had a DME dated after admission.

Plan: Inservice initiated with Clinical Service Manager and charge nurse on the proper timing of a DME when a resident will be located int █████ SDCU. See attached. Will be completed by 5/9/25. Clinical Service manager will pull all memory care residents charts to check the dates by 5/15/25.

Sustain: Clinical Service Manager will review each admission with Administrator before 30 days of admission. If a candidate for SCDU, admission will be reviewed day of admission or before. to ensure DME is completed PRIOR. See attached audit with outline. Review will take place weekly x 3 months to ensure accuracy.

Licensee's Proposed Overall Completion Date: 05/13/2025

Implemented (████) - 06/26/2025)

233c - Key-Locking Devices

10. Requirements

2600.

233.c. If key-locking devices, electronic cards systems or other devices that prevent immediate egress are used to lock and unlock exits, directions for their operation shall be conspicuously posted near the device.

233c - Key-Locking Devices (continued)

Description of Violation

The directions for operating the home's locking mechanism are not conspicuously posted near the exit door by room [REDACTED] in the [REDACTED]

Plan of Correction

Accept [REDACTED] - 05/20/2025)

Issue: The code for the alarmed door in the SDCU was too far from the keypad located at the top of the corner and in an emergency could be too difficult to find.

Action: Clinical Service Manager immediately placed the code closer to the keypad. Inservice was initiated by Clinical Service Manager with education given on the appropriate locations acceptable for the ability to locate the code in a timely manner in the case of an emergency situation. See attached.

Plan: Staff will continue to be educated by Admin and CSM on the appropriate locations and report if the code is not within the area. All staff will be educated by 5/20/25.

Sustain: Administrator has added the EXIT doors to the monthly audit sheet. The start date was 5/12/25 for the monthly audit and will be completed by the Med Tech on the 3-11 shift. This will remain in place as a permanent correction as attached.

Licensee's Proposed Overall Completion Date: 05/17/2025

Implemented ([REDACTED] - 06/26/2025)